HOSPITAL WORKSHEET

CHILD

MEDICAL RECORD NUMBER OF CHILD | METABOLIC CARD NUMBER | MEDICAL RECORD OF MOTHER

CHILD'S NAME (first) (middle) (last) (suffix)

TIME OF BIRTH | DATE OF BIRTH | SEX (M) | PLURALITY - Single, Twin, Triplet (Specify) | IF NOT SINGLE BIRTH, First, Second, Third, etc. (Specify)

CERTIFIER'S NAME AND TITLE (print or type) | DATE CERTIFIED | ATTENDANT'S NAME AND TITLE IF OTHER THAN CERTIFIER

MOTHER INFO

MOTHER'S CURRENT LEGAL NAME (first, middle, last) | MOTHER'S FULL NAME BEFORE FIRST MARRIAGE (first, middle, last) | MOTHER'S DATE OF BIRTH

MOTHER'S STATE OF BIRTH (and name of country if not USA) | MOTHER'S RESIDENCE ADDRESS (#, n-s-e-w, street name, street type, n-s-e-w, apt #, state/country, county, city/village/twp, zip+ext)

WITHIN CITY LIIMITS ☐ Yes ☐ No ☐ Unknown | MOTHER'S MAILING ADDRESS IF DIFFERENT FROM RESIDENCE (#, n-s-e-w, street name, street type, n-s-e-w, apt #, state/country, city/village/twp, zip+ext)

CURRENT MARITAL STATUS
☐ Never Married ☐ Married but Refusing Husband's Information
☐ Currently Married
☐ Divorced/Widowed ☐ Unknown

WAS MOTHER MARRIED AT BIRTH OR CONCEPTION? ☐ Yes ☐ No ☐ Not Applicable

DID A COURT RULE THAT THE HUSBAND WAS NOT THE FATHER? ☐ Yes ☐ No ☐ Not Applicable

DO YOU INTEND TO FILE AN AFFIDAVIT OF PARENTAGE? ☐ Yes ☐ No ☐ Not Applicable

INFORMANT'S NAME IF DIFFERENT FROM MOTHER (first, middle, and last)

MOTHER'S SOCIAL SECURITY NUMBER

MOTHER'S EDUCATION
☐ 1. 8th grade or less
☐ 2. 9th-12th grade; no diploma
☐ 3. High school graduate or GED
☐ 4. Some college but no degree
☐ 5. Associate degree (AA, AS)
☐ 6. Bachelor's degree (BA, AB, BS)
☐ 7. Master's degree (MA, MS, MEng, MEd, MSW, MBA)
☐ 8. Doctorate or Professional degree (PhD, EdD, MD, DO, DDS, DVM, LLB, JD)
☐ 9. Unknown

FATHER INFO

FATHER'S CURRENT LEGAL NAME (first, middle, last, suffix) | FATHER'S DATE OF BIRTH | FATHER'S BIRTHPLACE (state, territory, or foreign country)

FATHER'S RESIDENCE ADDRESS (if different than mother's)

FATHER'S SOCIAL SECURITY NUMBER

FATHER'S EDUCATION
☐ 1. 8th grade or less
☐ 2. 9th-12th grade; no diploma
☐ 3. High school graduate or GED
☐ 4. Some college but no degree
☐ 5. Associate degree (AA, AS)
☐ 6. Bachelor's degree (BA, AB, BS)
☐ 7. Master's degree (MA, MS, MEng, MEd, MSW, MBA)
☐ 8. Doctorate or Professional degree (PhD, EdD, MD, DO, DDS, DVM, LLB, JD)
☐ 9. Unknown

MEDICAL ADMIN

DID MOTHER RECEIVE PRENATAL CARE? ☐ YES ☐ NO ☐ UNKNOWN | DATE OF FIRST VISIT (month/day/year) | DATE OF LAST VISIT (month/day/year)

TOTAL PRENATAL VISITS | LIVE BIRTHS NOW LIVING (do not include this birth) | LIVE BIRTHS NOW DEAD (do not include this birth)

DATE OF LAST LIVE BIRTH (month/year) | OTHER TERMINATIONS (spontaneous and induced at any time after conception)

DATE OF LAST OTHER TERMINATION (month/year) | DATE LAST NORMAL MENSES BEGAN | OBSTETRIC ESTIMATED GESTATION (Weeks)

CHILD'S BIRTH WEIGHT (specify unit) | APGAR SCORE 5 min ☐ 10 min ☐ | HOSPITAL NAME (If not hospital, street name and number)

IS INFANT STILL LIVING AT TIME OF REPORT ☐ YES ☐ NO | DATE BABY DIED (month/day/year) | IS INFANT TO BE ADOPTED? ☐ YES ☐ NO

MOTHER STAT

HISPANIC ORIGIN ☐ YES ☐ NO

ANCESTRY
☐ MEXICAN ☐ PUERTO RICAN ☐ CUBAN ☐ CENTRAL OR SOUTH AMERICAN ☐ CHICANO ☐ OTHER HISPANIC ☐ AFRO-AMERICAN ☐ ARAB ☐ ENGLISH ☐ FRENCH ☐ FINNISH ☐ OTHER (specify) _____

RACE
☐ AMERICAN ☐ AMERICAN INDIAN ☐ BLACK ☐ WHITE ☐ OTHER _____

IF ASIAN, SPECIFY NATIONALITY
☐ CHINESE ☐ FILIPINO ☐ ASIAN INDIAN ☐ OTHER _____

FATHER STAT

HISPANIC ORIGIN ☐ YES ☐ NO

ANCESTRY
☐ MEXICAN ☐ PUERTO RICAN ☐ CUBAN ☐ CENTRAL OR SOUTH AMERICAN ☐ CHICANO ☐ OTHER HISPANIC ☐ AFRO-AMERICAN ☐ ARAB ☐ ENGLISH ☐ FRENCH ☐ FINNISH ☐ OTHER (specify) _____

RACE
☐ AMERICAN ☐ AMERICAN INDIAN ☐ BLACK ☐ WHITE ☐ OTHER _____

IF ASIAN, SPECIFY NATIONALITY
☐ CHINESE ☐ FILIPINO ☐ ASIAN INDIAN ☐ OTHER _____

MED STAT

MOTHER TRANSFERRED PRIOR TO DELIVERY? ☐ YES ☐ NO | IF YES ENTER NAME OF FACILITY TRANSFERRED FROM | MOTHER'S HEIGHT (in feet and inches) | MOTHER'S WEIGHT AT DELIVERY (pounds) | MOTHER'S PREPREGNANCY WEIGHT (pounds)

DID MOTHER SMOKE BEFORE OR DURING PREGNANCY? ☐ YES ☐ NO | DID MOTHER QUIT SMOKING? ☐ YES ☐ NO | DATE MOTHER QUIT SMOKING | OTHERS IN HOUSEHOLD SMOKE? ☐ YES ☐ NO | DID MOTHER RECEIVE W.I.C.? ☐ YES ☐ NO ☐ UNKNOWN

BREAST FEEDING INITIATED, PLANNED, OR NOT PLANNED? ☐ INITIATED ☐ PLANNED ☐ NOT PLANNED ☐ UNKNOWN

EXPECTED SOURCE OF PAYMENT FOR MEDICAL SERVICES (Private Insurance, Medicaid, etc.)

INFANT TRANSFERRED ☐ YES ☐ NO ☐ UNKNOWN | IF YES, FACILITY TRANSFERRED TO | SOCIAL SECURITY REGISTRATION REQUESTED ☐ YES ☐ NO ☐ UNKNOWN

SIGNATURE OF MOTHER OR INFORMANT _____

ONSET OF LABOR (Check all that apply)

- ☐ 01 Premature Rupture of the Membranes (prolonged >= 12 hrs.)
- ☐ 02 Precipitous Labor (<3 hrs.)
- ☐ 03 Prolonged Labor (>= 20 hrs)
- ☐ 00 None of the above
- ☐ 99 Unknown

OBSTETRIC PROCEDURES (Check all that apply)

- ☐ 01 Cervical cerclage
- ☐ 02 Tocolysis

External cephalic version:

- ☐ 03 Successful
- ☐ 04 Failed
- ☐ 00 None of the above
- ☐ 99 Unknown

METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No ☐ Unknown

B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No ☐ Unknown

C. Fetal presentation at birth
☐ 01 Cephalic
☐ 02 Breech
☐ 03 Other
☐ 04 Unknown

D. Final route and method of delivery (Check one)
☐ 01 Vaginal/Spontaneous
☐ 02 Vaginal/Forceps
☐ 03 Vaginal/Vacuum
☐ 04 Cesarean

If cesarean, was a trial of labor attempted?
☐ Yes ☐ No
☐ Not applicable ☐ Unknown

Was cesarean needed to prevent disease transmission, i.e.: HIV, Gential Herpes, etc.?
☐ Yes ☐ No
☐ Not applicable ☐ Unknown

CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

- ☐ 01 Induction of labor
- ☐ 02 Augmentation of labor
- ☐ 03 Non-vertex presentation
- ☐ 04 Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ☐ 05 Antibiotics received by the mother during labor
- ☐ 06 Clinical chorioamnionitis diagnosed during labor or maternal temperature =>38 degrees C (100.4 degrees F)
- ☐ 07 Moderate/heavy meconium staining of the amniotic fluid
- ☐ 08 Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- ☐ 09 Epidural or spinal anesthesia during labor
- ☐ 00 None of the above

MATERNAL MORBIDITY (Check all that apply) (complications associated with labor and delivery)

- ☐ 01 Maternal transfusion
- ☐ 02 Third or fourth degree perineal laceration
- ☐ 03 Ruptured uterus
- ☐ 04 Unplanned hysterectomy
- ☐ 05 Admission to intensive care unit
- ☐ 06 Unplanned operating room procedure following delivery
- ☐ 00 None of the above
- ☐ 99 Unknown

RISK FACTORS IN THIS PREGNANCY (Check all that apply)

Diabeles
- ☐ 01 - Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ 02 - Gestational (Diagnosis in this pregnancy)

Hypertension
- ☐ 03 - Prepregnancy (Chronic)
- ☐ 04 - Gestational (PH, preeclampsia, eclampsia)
- ☐ 05 Previous preterm birth
- ☐ 06 Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ 07 Vaginal bleeding during this pregnancy prior to the onset of labor
- ☐ 08 Pregnancy resulted from infertility treatment
- ☐ 09 Mother had a previous cesarean delivery -- If “yes,” how many _____
- ☐ 10 Alcohol use during pregnancy
- ☐ 00 None of the above
- ☐ 99 Unknown

INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

- ☐ 01 Gonorrhea
- ☐ 02 Syphilis
- ☐ 03 Genital Herpes
- ☐ 04 Chlamydia
- ☐ 05 Hepatitis B
- ☐ 06 Hepatitis C
- ☐ 07 Group B Strep
- ☐ 00 None of the above

Was Maternal HIV Test Performed?
☐ Yes ☐ No
☐ Unknown

ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)

- ☐ 01 Assisted ventilation required immediately following delivery
- ☐ 02 Assisted ventilation required for more than six hours
- ☐ 03 NICU admission
- ☐ 04 Newborn given surfactant replacement therapy
- ☐ 05 Antibiotics received by the newborn for suspected neonatal sepsis
- ☐ 06 Seizure or serious neurologic dysfunction
- ☐ 07 Significant birth injury (skeletal fracture[s], peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
- ☐ 00 None of the above
- ☐ 99 Unknown

CONGENTIAL ANOMALIES OF THE NEWBORN (Circle all that apply)

- ☐ 01 Anencephaly
- ☐ 02 Meningomyelocele/Spina Bifida
- ☐ 03 Congenital heart disease
- ☐ 04 Cyanotic congenital heart disease
- ☐ 05 Congenital diaphragmatic hernia
- ☐ 06 Omphalocele
- ☐ 07 Gastroschisis
- ☐ 08 Limb reduction defect excluding congenital amputation and dwarfing sydrome
- ☐ 09 Cleft lip with or without cleft palate
- ☐ 10 Cleft palate alone

Down Syndrome
- ☐ 11 - Karyotype confirmed
- ☐ 12 - Karyotype pending

Suspected chromosomal disorder
- ☐ 13 - Karyotype confirmed
- ☐ 14 - Karyotype pending
- ☐ 15 Hypospadias
- ☐ 16 Other congenital anomalies (specify) _____

_____

- ☐ 00 None of the above
- ☐ 99 Unknown

Date Immune Globulin given: _____

EHDI INFORMATION

INITIAL SCREEN RESULTS

Was a Hearing Screen Performed? _____
Date Screened: _____
Screen Method: _____
Results of Left Ear: _____
Results of Right Ear: _____

Reason Hearing Screening Not Performed: _____
_____
_____

SECONDARY SCREEN RESULTS

Was a Second Hearing Screen Performed? _____
Date Screened: _____
Screen Method: _____
Results of Left Ear: _____
Results of Right Ear: _____

Reason Hearing Screening Not Performed: _____
_____
_____

IMMUNIZATION GUI

Was Hepatitis B immunization given to infant?
☐ Yes ☐ No ☐ Unknown Date Hepatitis B given: _____

Was Hepatitis B Immune Globulin given?
☐ Yes ☐ No ☐ Unknown Date Immune Globulin given: _____